EMPLOYEE INCIDENT REPORT (EIR)
(No Medical Treatment Required)

Name: _____ Age: _____ Personnel #: _____

Address: _____
Street City AR Zip

Home/Phone: _____ Cell Phone: _____

Job Title: _____

Agency Name: _____

Agency Address: _____
Street City AR Zip

Date of Accident: _____ Time of Accident: _____

Location Where Incident Occurred: _____

Descripiton of Incident: _____

_____

_____

Body Parts Injuried: _____

Seat Belt Properly Used: _____ Yes _____ No _____ N/A

Opinion of Supervisor: _____ Preventable _____ Non-Preventable

Witness of Accident Address

_____ _____

_____ _____

Injured Employee Signature: _____

Supervisor (Please Print): _____

Supervisor Signature: _____

Supervisor Phone Number: _____ Date: _____

Contact Information:
Vannessa Chambers, (501) 682-2744 Fax: (501) 682-4487
ADE Human Resources Office
Four Capitol Mall, Room 106 A, Little Rock, 72201